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ST. PETER REGIONAL TREATMENT CENTER

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I. INTRODUCTION

In addressing the so-called "continuum of care", the state hospital system has been considered the forerunner and bastion for the provision of mental health services in the State of Minnesota. As societal expectations and tines have changed, there have been a number of new developments and different methods of approaching the mental health needs of the persons with mental illnesses and developmental disabilities. These new approaches have in many ways met some of the needs which were, and are, prevalent in today's society. Resulting from these new approaches has been a change in the role and delivery of service of the modern state hospital (regional treatment center).

The hospital of today is seen as a regional resource for those types and degrees of mental illness or disability which cannot be effectively treated by existing community resources. The St. Peter State Hospital is a classic example of this ongoing evolution as follows:

1. The St. Peter State Hospital was the first institution established in the State of Minnesota for the care and treatment of the men tally ill person, and has been in existence since 1865.

2. As a part of the history of the St. Peter State Hospital, treat ment components for the chemically dependent, mentally retarded, and a forensic facility for the mentally i11 and dangerous have been added to the original facility's role and purpose.

3. The St. Peter State Hospital is by its unique organization a regional facility for the mentally retarded for Region IX, a multi-regional treatment facility for the mentally ill and chemi cally dependent for Regions IX and X, and a statewide treatment and evaluation facility for the mentally ill and dangerous for the entire State of Minnesota.

4. The St. Peter State Hospital has a present licensed bed capacity of 674, and currently is operating at over 90% occupancy.

5. During the past 12 months, the St. Peter State Hospital has absorbed the admission and treatment responsibilities of the former Rochester State Hospital, and, as a result, has increased its admission rate by 16%.

6. The St. Peter State Hospital operates the only forensic psychiatric unit (Minnesota Security Hospital) in the State of Minnesota and has just completed occupancy of a new $10 million, modern and secure psychiatric facility.

7. The St. Peter State Hospital is licensed by the Department of Public Welfare under Rules 3, 34, 35 and 36, and is the first state institution in Minnesota to be accredited by the Joint Commission on Accreditation of Hospitals for a three-year period.

8. Almost 50% of the hospital's annual budget, $16 million, is reim bursed to the State of Minnesota, General Revenue Fund, through federal reimbursement and third-party payees,

9. With over 700 employees, the St . Peter State Hospital is St. Peter's largest employer and accounts for 32% of all wages paid in the City of St. Peter and approximately 10% of all wages in Nlcollet County,

10. While current statistics indicate that the admissions to the St. Peter State Hospital have increased significantly during the past year, our Program Evaluation Department indicates that we have continued to reduce recidivism to a current average of 30% for the mentally ill and 22% for the chemically dependent; we have main tained a median length of stay of 64 days for the mentally ill and 28 days for the chemically dependent.

While this report addresses itself to the impact of closure of a state hospital, it is evident that with an increasing population growth and decreased federal and state financial assistance, communities are and will continue to be unable to respond to the acute and severely psychotic individual's needs$_t$ as well as to those with severe and profound mental disabilities. Our contacts with the counties in our catchment area, with community support facilities, and with the general public confirm what we as *a* regional hospital are experiencing, namely, that there is an ever-increasing need for a state facility that is well-staffed and operated to provide for the care of citizens who are unable to receive specialized treatment anywhere else in the community.

II. ST. PETER STATE HOSPITAL

St. Peter State Hospital, one of three treatment facilities in the St. Peter Regional Treatment Center, is a 234 bed general psychiatric hospital offering treatment services to the mentally i l l, including the psychogeriatric population, and the chemically dependent. The 19 counties served include:

Nicollet	Faribault	Dodge
Brown	Rice	Mower
Watonwan	Waseca	Wabasha
Martin	Freeborn	Olmsted
LeSueur	Steele	Fillmore
Blue Earth	Goodhue	Winona
	Houston	

St. Peter State Hospital operates on *a* multi-disciplinary Treatment Team approach on all units and Is organized on *a* unit/department basis which function very successfully. All treatment modalities are available including (psychiatric/medical, psychological, social services, vocational, nursing, rehabilitation (including a broad work program), behavior analysis, complete medical records services, and special rehabilitative services by referral.

St. Peter State Hospital is the only state psychiatric facility to receive a full three (3) year accreditation from the Joint Commission on Accreditation of Hospitals; St. Peter State Hospital also continued its full licensure under DPW Rule 35 (chemical dependency) and 36 (mental illness) as well as certification by the Minnesota Department of Health including HEW Title 18 and 19. The present capacity of the hospital has been utilized at a 96+ - 98+% rate on a continuous basis since January 1982, and these figures will undoubtedly hold constant since the existing catchment area includes a population of 600,000+.

III. IMPACT ON CLIENTS

A. Mental Illness Program

With St. Peter State Hospital not serving the needs of the mentally ill persons, those in need would have to be served by Willmar and Fergus Falls State Hospitals. As St. Peter serves a 19 county area, the round trip distance for a county, if St. Peter were bypassed, would be an additional four (4) hours to Willmar and seven to eight hours if Fergus Falls were utilized.

Given the greater distance, it would be safe to assume the cost to the county of referral would be increased. With financial limitations, more mentally ill in need of acute or chronic care would be allowed to remain in the community. The consequence would seem to be the likelihood of more violent behaviors and crimes. As a response, jails and psychiatric wards of hospitals (local) would have to be utilized. Jails, traditionally, make minimal distinction between the criminal and the mentally ill, and this would be detrimental to the needs of persons in need of psychiatric care. Local hospitals with psychiatric units tend to work with the acute care mentally ill and one who has financial means to pay for such care. The needy mentally i11 person would probably be excluded.

The distance from the county of referral would seriously hinder re-introducing the resident back into the community. This would occur because the community resources would be far removed from the serving hospital. County social workers would also be geographically removed from the serving hospital and consequently would have minimal contact with the resident and treatment team. This combination would reduce the speed of discharge to the community and would reduce the possibility of utilizing the most beneficial placement. This is because group homes or halfway houses funded by the county of referral are generally located in that county. It will be more expensive for the resident, in terms of time and money, to commute to the interview, pre-screening, and eventual placement.

An integral part of re-introducing the resident back into his community is to develop a positive relationship with the family of the client. This includes at times, family counseling sessions. This is essential because it provides the resident with a base of support when they leave the hospital. With the resident now removed from his county of residence, such sessions are expensive and time consuming for the family. With the resident in the two aforementioned hospitals, the distance would make such sessions impractical. This, then would have a significant impact on discharges.

The distance factor would tend to impact upon the length of stay. We are well aware that attempts need to be made to discharge residents as they peak. To be unable to do so encourages greater likelihood of institutionalization and return to custodial care.

If distance from the serving county does become a factor in determining whether to place a mentally ill adult, then we must be reminded of the following:

That previous reduced reliance on the state hospital for all services for the chronically mentally i11 patients has made evident the inadequacy of the community's ability to provide for their basic human needs for shelter, food, and clothing, *AS* well as income, employment, and meaningful daily activities. Furthermore, opportunities for needed services, including health, mental health, rehabilitation, and education, have been insufficient. These people can be seen wandering the streets in many cities in the nation today.

Approximately 20 patient (mentally 111) at St. Peter are awaiting jobs and/or community placement at this time. They have no resource or family support group. If the hospital were not a resource to them, they would be conceivably without food or shelter at this time or on the welfare rolls.

If St. Peter State Hospital did not house mentally ill adults, then the possibility would exist that the same amount of mentally ill adults would have to be provided far in fewer facilities. This would result in over-crowding, and would reduce the potential for individualizing programs based on individual resident need and create an environment more indicative of "warehousing". Further, it would isolate the mentally ill patient by creating "pockets" of residents who are mentally ill in smaller areas. There are strong indications that if the public is allowed to interact with the mentally ill in situations that allow the mentally ill person to be perceived as "normal", the attitudes of the public will shift in a positive direction. This has certainly been the case at St. Peter State Hospital.

Another segment of the community impacted by St. Peter State Hospital's not serving the mentally ill would be those programs that work with that popula-tion. They include Horizon Homes I and [I and Mankato Rehabilitation Center. They draw heavily on our population that are nearing discharge.

The mentally ill programs utilize volunteers from colleges (Gustavus Adolphus) as well as social clubs in the community. These participants pro-vide needed one-to-one special attention to residents who don't have fami-lies, but more importantly it brings the community closer to the mentally ill adult. It provides the community with a more human understanding of the life and needs of the mentally ill. Any volunteer activity, i . e . , visiting hospitals, helping in rehabilitation, will lead to greater support for and greater advances in positive mental health. This may bo even more so than intellectually-oriented mental health programs.

Professionals at St. Peter State Hospital's mentally ill units provide an educational function to the community, participating in speaking engagements that relate to all aspects of mental health as well as trends in the mental health field. This encourages a very positive relationship between the hospital and the community, and it further enhances opportunities for residents to work in the community. Professionals are also members on an active basis in such groups as the Lion's Club and the Jaycees. They take an active part in their civic duties and serve on numerous boards in the community.

Most importantly, the chemotherapy revolution has changed the lot of mentally ill persons. Often when first administered, a secure environment is required to protect the patient, observe, and then control side effects and protect the community. St. Peter State Hospital serves these vital functions by offering a sheltered environment. This also ensures a more rapid reintroduction to the community and, thus, a decreased cost to the taxpayer.

St. Peter State Hospital has established an effective treatment program which is an integral part of the community treatment program. It provides highly specialized services for the mentally ill, serves as a backup treatment center for overburdened community programs or for prolonged treatment of persons who have not responded to other community treatment programs, and provides services to persons who are unable to pay for services within the community mental health system. St. Peter State Hospital continues to serve a meaningful function in the mental health system, treating chronically mentally ill persons and other special groups, in part to meet clinical needs and in part to fill a critical gap due to the pervasive lack of alternatives as well as providing acute care and specialized services.

One area that St. Peter State Hospital meets is the religious needs of residents. Many of these residents in the community do not have vehicles or the opportunity to attend services. Services are provided on the St. Peter State Hospital grounds, and one priest and one minister are available for consultation.

B. Chemical Dependency Program

The following report attempts to outline the impact of Johnson Chemical Dependency unit (J.C.D.U.) on the 19 county catchment area designated by the Department of Public Welfare to St. Peter State Hospital. The report is meant to be a statement regarding anticipated ramifications on the client, county, and regional area in the event the services provided by J.C.D.U. were no longer available.

Johnson Chemical Dependency Unit accepts clients from a variety of referral sources: (1) commitments; (2) Minnesota Department of Public Safety (as requirement for restoration of driving privileges); (3) secure correctional facilities recommended as transitional phase in re-entry to community; (A) in lieu of jail/condition of probation per recommendation of correctional agent; (5) county social services agency; (6) self-referral.

J.C.D.U. treats the indigent, chronic disabled (i.e., those with emotional, physical or functional handicaps), most of whom would be precluded from participation in private treatment programs by virtue of these conditions.

J.C.D.U. provides the following services in addition to primary and extended care programming:

- Family Program (education, problem identification, referrals)
- Aftercare (free of charge, available to clients/families on weekly basis, available to persons residing in catchment area who have completed any C.D. treatment program)
- AA/Alanon (open to public twice weekly)
- Follow-up (monthly telephone contact for up to two years following discharge)
- Public Relations (staff is available to speak to service and other community clubs upon request; with inclusion of 11 counties in catchment area within the past year staff has met with county personnel in an effort to establish constructive working relationships and enhance con tinuum of care)
- Division of Vocational Rehabilitation services as part of comprehensive team effort
- Information and Referral (sometimes first contact for persons requesting information regarding chemical dependency and/or treatment; provide community resource information to clients and C.D. professionals in southern Minnesota area)
- C.D. Assessments and Treatment for Residents of Other Unite on S.P.R.T.C. Campus

J.C.D.U. *is* involved in a longitudinal evaluation of the program. The long-term goal of the study is to provide the data necessary to tailor a C.D. program which directly responds to the needs of the persons served and enables them to return to and remain in the community as productive members. A literature search indicates the uniqueness of this project in that it is state-hospital based, longitudinal, and a developmental as well as summative process.

Private treatment facilities (both in/out patient) are available in the area. However, cost is prohibitive for indigent persons without insurance. St. Peter State Hospital Reimbursement Office reports that 80% of persons admitted for treatment at J.C.D.U. would not be eligible for services provided by private facilities due to lack of personal funds and county funding constraints. Persons unable to afford the cost and given no alternative to private treatment could conceivably be denied treatment altogether.

Other state institutions can serve the same type of population as J.C.D.U.; however, distance and related factors are prohibitive. The farthest point in J.C.D.U. catchment area is approximately 150 miles from St. Peter. Referral to Willmar State Hospital would place an additional 100 miles on this figure and to Fergus Falls State Hospital, an additional 200 miles. Problems inherent in the added distance Include:

- travel time and transportation cost to family and county personnel
- transporting personnels' objection (i.e., Sheriff's Office)
- difficulty coordinating community placement/continuum of care due to distance and unfamiliarity

Given these prohibitive factors, it is conceivable that a percentage of prospective admissions would simply elect to forego treatment.

In sum, J.C.D.U. provides services to .1 number of agencies and individuals within the Region. Discontinuation of these services would not likely result in a transfer of responsibility to other sources; rather, county budget constraints and pragmatic obstacles involving the distance factor would preclude the provision of quality services to the chemically dependent.

C. Psycho-geriatric Program

This unit serves the 19 county area of southern and southeastern Minnesota with a population of 600,000+. The Geriatric Unit has 34 beds, and the amount of total nursing care varies with admissions. The types of problems dealt with include: Schizophrenia in elderly persons as well as all forms of Organic Brain Disease. This population requires a high level of physical care and supervision as many of these patients require bathing, feeding, dressing, toileting, activity motivation, social Interaction by others, and environmental stimulation. The Mentally I11 Geriatric Unit admits and discharges approximately 25 persons per year, and there is no comparable alternative for the population served in southern Minnesota*

As studies have shown, moving an elderly person from familiar surroundings has a very traumatic impact on both the physical and mental health of those persons. The geriatric program attempts to stabilize and improve the physical and mental status of its patients and return them to a familiar environment. Family visits also facilitate this process. Closing this unit would mean the geriatric patient who needed psychiatric care would need to be treated at a state facility, i.e., Willmar, Moose Lake or Fergus Falls, which is many added miles from home as most cannot afford private care in their own geographic area. This would decrease if not eliminate family support through visits and participation in treatment and discharge planning. It would also mean a rise in costs to the counties with decreased county Involvement in treatment and discharge planning. If placement does not occur in the patient's home area, aftercare and follow-up would be non-existent because of the distance involved.

Many of the patients PECU serves have been unable to maintain themselves in the community due to their mental illness. They have not even been able to maintain placements in nursing homes due to severe behavioral problems. Currently, community resources available to the elderly persons in need of treatment for mental Illness are practically non-existent. The two state nursing homes are usually filled to capacity, and the other viable resources, mental health centers, are not only usually under-funded, but the geriatric population historically constitutes a very small percentage of their clients.

IV. MINNESOTA VALLEY SOCIAL ADAPTATION CENTER

Minnesota Valley Social Adaptation Center was developed in 1968 on the St. Peter State Hospital campus utilizing a number of buildings formerly used to care for the mentally i11. The Center was established to provide care and training for ambulatory mentally retarded adults from the geographic area now referred to *as* Regions 9 and 8, and also Scott and Carver Counties in

Region 11. The Center was the first major residential program for the retarded to be developed in a hospital for the mentally ill. Six other hospitals in the state system eventually established multiple programs for MI-MR and CD clients.

This major change in Minnesota's State Hospital system occurred at a time when de-institutionalization of the mentally ill was causing rapid decline in the hospitalized population of mentally ill. De-institutionalization of the mentally retarded population was at its apex. The three MR Institutions (Faribault, Cambridge and Brainerd) were disturbingly overcrowded. The public was becoming aware of the dehumanizing conditions provided the retarded and efforts had begun to examine state hospital programs and improve the conditions that existed. Utilizing available bed space vacated by the placement of the mentally ill seemed logical.

The establishment of regional state facilities for the mentally retarded preceded the de-institutionalization movement of the retarded. Since the late 1960s the numbers of institutionalized MRs as well as the mentally ill have dramatically been reduced. During this period the development of community services for the mentally retarded occurred rapidly. In 1971, the population of MVSAC approached 400, whereas the current population. (6-1-82) is 183 and two regional state MR facilities in Southern Minnesota have been closed, Rochester and Hastings. The presence of regional MR facilities obviously affected this rapid decline as communities became more readily aware of their hospitalized clients and regional facility staff were frequently key personnel in community service development efforts.

Of the 183 resident at MVSAC, 163 have residence in the MVSAC receiving district, and the other 20 are from counties of residence outside of our receiving district. The majority of these residents have remained at MVSAC due to family requests because parents live in our region or for other personal reasons.

COUNTY UTILIZATION

Region IX	MVSAC (6/1/82)	Region XI	MVSAC (6/1/82)
Blue Earth	34	Carver	10
Brown	22	Scott	15
Faribault	20		
LeSueur	17	Others	20
Martin	9		
Nicollet	12		
Sibley	12		
Waseca	5		
Watonwan	7		

During the past five years (1977-81), 43 residents have been admitted from our receiving area or an average of eight: admissions per year. This number does not include transfers from other hospitals or respite care admissions. These are long-term care admissions. During this same period, 97 residents were discharged to the community or an average of 19 per year. This number

again does not include respite care, deaths or transfers. The net reduction in population at MVSAC has averaged about 10 per year. At this present **rate** of reduction, MVSAC over the next five years would be at a population of 133 which is very close to the required population reduction specified by the Welsch-Noot Consent Decree.

Within MVSAC'e eleven-county receiving area there are currently 409 ICF-MR beds and additionally a growing number of SILS placement opportunities.

ICF-MR/ RULE 34 LICENSED BEDS

Blue Earth	95
Brown	28
Faribault	19
LeSueur	14
Martin	50
Nicollet	0
Sibley	15
Waseca	18
Watonwan	0
Carver	112
Scott	58
	409

There are two proposed projects currently approved by DPW which would add 31 additional ICF-MR beds within the next year.

The development of ICF-MR beds in the MVSAC receiving area has occurred over the past 10 to 13 years. If the availability of community services continues to grow at a similar rate of development over the next five years, it is conceivable that the estimated population drop at MVSAC may be higher than projected. Numerous factors, however, tend to alter the development rate including current economic pressures which have slowed development. What effect the projected closure of MVSAC would have is very difficult to determine. It is probably safe to conclude that general economic factors have the greater effect on community service development.

State hospital populations today consist primarily of the most severely handicapped individuals. The majority of the borderline, mild and moderately retarded individuals have moved to the community. State hospitals also are experiencing fewer admissions due to the availability of community programs. The individuals who are admitted today primarily present severe behavioral problems. The severity of the problems is currently beyond the coping ability of the community programs. However, the ability of state hospital programs to deal with the behavior disordered client has improved significantly. Therefore, admission of this type of client is seen as being the service of choice not of last resort. In some cases state hospital admission is seen as being essential due to lack of other alternatives but only short-term until other community alternatives become available.

The majority of mentally retarded persons being served by community programs are very much dissimilar to the majority of individuals served by the state.

hospitals. Current literature supported by rather extensive research supports this conclusion. The de-institutionalization of present state hospital residents will require the development of vastly different community programs than what currently exists. Thus, the impact of closure of MVSAC would require the placement of the MVSAC's residents in other state facilities as the majority of them (72%) are severely and profoundly handicapped.

FUNCTIONAL LEVEL		
Borderline Mental Retardation	3	2%
Mild Mental Retardation	10	6%
Moderate Mental Retardation	29	16%
Severe Mental Retardation	61	33%
Profound Mental Retardation	72	39%
Unspecified Mental Retardation	8	4%
	183	100%

If closure only fosters crowded and larger institutions improved services are unlikely to occur.

As indicated earlier, the development of the regional MR facility did have a presumed positive and influential effect on community service delivery development in the Region. The closing and removal of MVSAC at this time may significantly alter the presence of the state hospital programs in their relationship with community programs. It is perceived that a negative effect would result. State hospital clients may again become more remote in relationship to their caretakers. Continuance of the de-institutionalization movement may be affected. The loss of the staff expertise in the Region would be significantly felt. In this Region, the Center has been very influential and a focal point for encouraging and planning development of services to the retarded. Its demise will require a re-focusing or redirection of this activity.

If MVSAC were to close the most appropriate state facilities to receive the Center's residents would be Faribault and Willmar. To many clients and their families the return to Faribault, and the elements of a larger institution, is seen as undesirable and counter to improved services and living environments. The development of multi-purpose state hospital programs was publicly accepted as a reform of previously inadequate services. The move to close is predominately accepted for an economical benefit. What will result in term of programs and services to the clients is not as easily apparent. Changes in the 1960s held out the promise of improved living environments, enriched staffing complements and locating clients closer to their homes and families. The closing of MVSAC would seem to diminish those benefits.

Regional facility staff, such as those at MVSAC have developed the strength of a close working relationship with county social services and human services staff, as well as community residential and day program providers. These relationships have created an environment for effective service to residents and their families. Several factors assist this relationship. Size of the staff group is smaller, thus the community worker is able to get to know Center staff personally. Through frequent contacts the clement of trust develops which fosters better planning of services for the resident. It is more convenient for community staff to get to the regional facility

when it is geographically closer. If residents are in large centrally located facilities it *is* expected that good community relationships which are vital to good programs would be difficult to maintain. The isolation of institutions, long a complaint, would again prevail.

The regional facility is beginning to reach out to be available to assist community agencies in providing service to their clients. The institutions serving as a resource in this manner is the outgrowth of their regional location and close relationships. Unless large central institutions consciously develop this type of service, community programs will lose a vital support link. The close working relationships that support easier transitions during admission and release of residents will also be gone. Residents will not be served and the de-institutional efforts become much more difficult to implement.

There is a rather strong argument against the development of large, central and isolated institutions. Due to their mere size, institutions tend to have insurmountable management problems which result in regimented care and violate the essence of normalization and individualization. They tend to provide "in house" programs thus lacking the opportunity for residents to have relationships and experiences within the normal community environment. The segregation, isolation and stigmatizing of their residents is destructive to health and development. Also, isolated locations make recruitment and retention of qualified professional staff difficult. Unless conscious and determined efforts are made to create an institutional environment that provides small home-like housing, enriched living and program environments, and a critical mass of competent well-trained staff, the criticism of large Institutions will be self-fulfilled.

The reform of institutions in Minnesota, which has occurred over the past 15 years, appears to now be in jeopardy if regional facilities such as MVSAC are closed. The ramifications would seem, based on historical experience, to be detrimental to quality resident care and community service development for the mentally retarded. Economic benefits may, on the surface, appear attractive, yet results of poorer services may eventually be extremely costly.

V. MINNESOTA SECURITY HOSPITAL

A. Population Served

Minnesota Security Hospital (MSH) is the only forensic facility in the State of Minnesota which provides specialized evaluation and treatment for mentally ill, mentally 111 and dangerous, and sexual offenders, including men and women age 18 and over. Occasionally, evaluations and treatment are provided to individuals under 18 years of age. This provides the probate and district courts with the advantage of maintaining procedural ties with one facility which the judges can more effectively use in providing for the safe and secure treatment of patients, and for the protection of the community. Minnesota Security Hospital admits individuals from all 87 counties in Minnesota and occasionally from other states. As of June 2, 1982, there were nine individuals being treated at Minnesota Security Hospital who were from another state.

If MSH were to be closed, the population from this hospital would have to be redistributed among the remaining state hospitals with a email percentage of the population referred back to corrections and/or courts. This redistribution, in addition to the cost of renovating several state hospitals' buildings to provide security, would also necessitate training and retraining staff to provide the kinds of specialized services necessary to admit, treat, and release these most difficult patients. Further, it would cause a great deal of confusion to the courts to redevelop forensic relationships with six state hospitals. A breakdown by receiving area of the in-house population as of June 2, 1982, for the MSH is as follows:

Anoka State Hospital receiving area	76
Brainerd State Hospital receiving area	11
Fergus Falls State Hospital receiving area	13
Moose Lake State Hospital receiving area	43
St. Peter State Hospital receiving area	24
Willmar State Hospital receiving area	16
Nonresidents at MSH	9
TOTAL	192

The programs at MSH are designed specifically for men and women who require a high security environment and intensive, expansive treatment. All areas at the St. Peter Regional Treatment Center (SPRTC) utilized by patients from MSH have been renovated to provide a high security setting for programming.

There are eight units which provide specialized programs in a high security setting. The eight specialized units are: chemical dependency, low functioning sexual offender, high functioning sexual offenders, short-term pre-discharge, therapeutic community, aggressive-acting out behavior, admissions, and women's unit.

Each unit provides a unique combination of treatment modalities for all patients. The following treatment modalities are provided: psychiatric evaluation, psychiatric individual and group counseling utilizing several psycho-therapeutic models, medical, psychological, social and family counseling, bio-feedback, vocational/work training, industrial-educational, recreational, and occupational/activity, community orientation, and academic training.

The Education Department is staffed by 13 special education teachers. The teachers provide individual tutoring and group instruction. Because of the type of patient in this hospital, educational efforts must be intensive and usually on an individual basis. This would be cost prohibitive to set up in six other hospitals. An individual patient's goal may be attainment of *a* G.E.D., high school diploma, or related to their educational maintenance. The Education Department provides these same services to the patients of St. Peter State Hospital.

B. Capacity Lost/P1acement of Patients

Should MSH close, the population from this facility would continue to need in-patient psychiatric care in a high security setting. Placement in adult programs at other state hospitals is possible. However, it would be very difficult and costly to duplicate the kinds and quality of services and facility that are presently provided at MSH in six separate state hospitals. There are problems finding qualified staff for one forensic facility; to provide qualified staff in six separate facilities would be extremely difficult.

The other factor which needs to be considered is the cost of constructing a building at each state hospital which would provide a high degree of security. At this time, no other state hospital has such a building. While it may be possible to remodel existing buildings to meet the security needs, our experience in constructing the new buildings and attempting to remodel old buildings to house MSH patients suggest that it may be necessary to construct an entirely new building at each state hospital for these patients who need a high degree of security in both their residential and programming areas.

In 1972-1973 a section of one building at the SPRTC was renovated for use as a low security setting. This renovation cost $227,300. The renovation consisted of installing security screens, door locks, and smoke dividers. This renovation was only in a living area; no programmatic space was renovated.

A new MSH was opened for evaluation and treatment in 1982 at a cost of $9,200,000. This funding was appropriated and contracts let for construction in 1978. Breaking the cost figures down for this hospital, it cost approximately $60,000 per bed to provide living and programmatic space. The cost for this same hospital today would be much higher than the figures quoted in 1978. Also, the figures given for renovation in 1972-73 would be closer to $500,000 for the same renovation. In addition, a lot of monies were spent to secure buildings at the SPRTC for programmatic use by the patients, of MSH.

From this it can be ascertained that to provide a high security facility with programmatic space at each state hospital would be an extremely costly project.

C. Impact on Patients

MSH is the only forensic facility in the State of Minnesota which provides treatment for the mentally i11 and dangerous patient. Patients would have very little, if any, treatment available if MSH were closed and would be deprived of the right to receive treatment. Since there is no similar state or private programs available for these patients, it is conceivable they would end up in a custodial care program and/or in the correctional system. Because of the extreme dangerousness of most of the MSH population, distributing them to other state hospitals could result in disastrous problems for both the receiving hospital as

well as the community at large. For example, it is highly probable that an increase in injuries for patients, staff and the public would occur without costly renovations to buildings or new construction.

D. Impact on Counties

Distribution of patients from MSH to other state hospitals would result in severe problems especially for urban counties. Populated counties such as Hennepin, Ramsey and St. Louis would face the prospect of having their mentally ill and dangerous patients spread out among several of the state hospitals, thereby greatly increasing their case management cost. For example, Hennepin County has approximately 60 patients receiving treatment at MSH. None of the other state hospitals would have the living and program spaces available to accommodate this large of an influx of mentally ill, dangerous, and sex offender patients. This is regardless of whether there is renovation or new construction projected for each state hospital.

E. Impact on Staff

The staff of MSH is unique in that they are specifically trained and experienced for the delivery of treatment services for the special population served. This staff has also had extensive training in security issues and techniques; legal status and commitments, especially pertaining to the mentally ill and dangerous, psychopathic personality, and sex offenders. The professional and direct care staff presently employed at MSH includes the following classifications: psychiatrists, physicians, nursing staff, psychologists, social workers, behavior analysts, rehabilitation therapists, vocational counselors, special education teachers, chemical dependency counselors, and attendant guards. Duplicating this same staff at six other state hospitals would be cost prohibitive even if these types of qualified staff could be recruited.

For additional information on impact; on staff, refer to appropriate section.

F. Impact on Community

The closing of MSH would have far-reached effects on the quantity and quality of educational training sites utilized by many educational institutions in the southern part of the state. Each year approximately 15-30 students are given practicum's in forensic treatment appropriate to their professional interests. This educational experience cannot be obtained, duplicated, or simulated in the depth and scope offered by MSH because there is no other forensic facility in the state. For additional information, refer to section on Educational and Training Activities.

Probably the greatest concern from the citizens of the communities is acceptance of such a facility in their community. There has been much concern expressed in the past when relocating Minnesota Security Hospital was being considered before the construction of the present facility in St. Peter.

b. Percent of County Income

The last available salary data were for the calendar year of 1980. Institutional salaries were adjusted for this same period. The institution's payroll amounts to about 8% of the total income (Minnesota taxable) for all of Nicollet County. It is estimated that the current total would be higher and closer to 10% due to:

(1) Increased number of staff here; and
(2) Declining farm income which has affected many businesses and other rural taxpayers.

2. Hospital Numbers of Employees

a. Percent of City Employment

3,830 part and full-time city jobs as of December, 1981 (Dept. of Energy, Planning & Development); of these, 702 - or 18.3% - were full-time equivalent hospital positions as of June 15, 1982.

b. Percent of County Employment

14,786 part and full-time employees in Nicollet County, according to 1981 Minnesota County Labor Force Estimates; the 702 hospital positions account for 4.7% of the county employment. Note that most county jobs are farm-related and would not be available to hospital employees in the event of lay-offs.

3. Revenue Lost to City

There is no single figure for "dollar expansion" or the "multiplier effect" from state jobs available for use. Such figures are usually from 1/6 to 2.5 additional jobs created for each new or existing job within a community. The lower figure is probably more applicable, as large amounts of services and goods are not purchased from our immediate region. There are a large number of "main street" businesses hovering between profit and loss that would probably have to go out of business if this hospital were to close. An estimate of the number of dollars spent locally (St. Peter, Mankato, LeSueur) on an annual basis would be: purchase of supplies, repairs to equipment, and purchase of provisions - $200,000; utility service to City - $180,000.00; communications - $75,000.00; natural gas and fuel oil - $600,000.00. Also, our residents/patients spend approximately $55,000.00 of 'their' money locally for personal needs. Due to the current unusual economic conditions, it is likely that a panic effect could raise the number of additional jobs lost to 200 or more.

4. Effects of Closure on Other Non-hospital Loss in the City/County

A nearby city, LeSueur, is going through a period of hardship since Pillsbury purchased Green Giant. A number of Green Giant management and staff employees were transferred to locations in the Twin Cities. At this time, the housing in LeSueur is priced 15-255 lower than St. Peter as a result. The same kind of loss could be anticipated in St. Peter with the loss of an even larger number of jobs. The current rental market appears to be roughly in balance with demand. Again, rent would have to drop at least 15-25% to attract: people from other cities like Mankato, and even then there would be a limit to the number willing to commute elsewhere to work. All citizens would suffer significant paper losses. It is estimated that 2,000 homes worth an average of $70,000 with a 20% loss in value would amount to a 52 million loss in St. Peter real estate. Other nearby smaller towns would also be affected.

St. Peter and its surrounding area could anticipate eventually losing population if 674 or more jobs were to be eliminated. At worst, this could amount to the 2,000+ people in households of hospital employees. Others indirectly affected and laid off in retail and service businesses supported by hospital employee salaries and purchases also would have to seek employment elsewhere. The school population could be reduced by one-fourth or more; a community hospital that is currently "Just getting along" would probably have to close; private organizations such as churches, a golf course, and an elementary school could face closure or bankruptcy. Unless some other industry could be found to employ people in the region, closure would be devastating.

B. Community Services - Educational & Training Activities

If St. Peter Regional Treatment Center or sections within the Center were not available for educational field experiences, an important aspect of its provision of services in education and training would not be available. Our programs offer valuable opportunities for students to explore career interests in working with one or more of our disability groups, as well as providing them with on job experiences.

Examples of educational opportunities we have offered, and which would no longer be available, are:

1. Vocational-Technical Schools

a. The Mankato Area Vocational Institute currently uses this hospital for "on-the-job" training for technicians planning to work in nursing homes or hospitals. There are no other large hospitals which can provide such training in this region. The class can be conducted in a single location for a combination of work and classes. At least 24-25 are in each class needing the "hands-on" experience we can provide. A smaller number of vocational students are sometimes placed

in other fields such as clerical/secretarial as well, but the numbers are changing from year to year. Two-week internships are also utilized for LPN students, and four-week, internships are available for Human Service Technician students.

b. The Faribault Area Vocational Technical Institute send 40-50 LPN trainees twice a year for a practicum in MI/CD training.

2. Professional Education (Graduate & Undergraduate)

a. Mankato State University

Students have placements in the fields of vocational rehabilitation, social work, psychology, nursing, recreational therapy, music, education and special education.

b. Gustavus Adolphus College

Students have placements in the fields of sociology, psychology, and music.

c. St. Olaf College

Chaplaincy training has been utilized for students.

3. Other Governmental Units

The Hospital Staff Development Department offers training sessions for employees of other governmental agencies and private nursing homes largely supported by governmental financing in the region. Each year, hundreds of hours of such training are secured here because it is not available elsewhere or available only at much greater expense. Recent discussions have been held with a professor of neurology at the Mayo Medical School concerning the availability of St. Peter Regional Treatment Center as a site for a brief field experience. In addition, the Mankato Area Vocational Technical Institute has made inquiries regarding the possible use of this campus for LPN clinical training and experience.

The foregoing information presents a picture of educational experiences which cannot be obtained, duplicated, or simulated in the depth and scope offered by the St. Peter Regional Treatment Center because no other state facility has this unique combination of disability groups as a source of learning.

VIII. ALTERNATIVE TREATMENT RESOURCES

Chemical Dependency

A. Primary In-Patient

Facilities located in Albert Lea, Rochester, Cannon Falls, and Mankato. There are no extended in-patient programs.

Out-Patient Treatment

Services are available in Mankato, Winona, Rochester, and Waseca - In addition to a number of private mental health professionals in the larger communities.

Halfway Houses

Several programs are located in Mankato, Fairmont, Austin, Rochester, Winona, and Owatonna.

Several homes are located in Rochester, New Ulm, Austin, Fairmont, and Mankato .

Mental Illness

A. Halfway Houses

One each in Mankato, Rochester, and Winona.

B. Crisis Centers

Two facilities are currently available in Waseca and Albert Lea.

C. Mental Health In-Patient Units

Only two hospitals in Rochester and Mankato offer a full treatment program.

D. Day Treatment

Services are available in Austin and Mankato as well as two day care centers in Winona and Rochester.

Sheltered Workshops/Vocation Rehabilitation Services

Services are located in several communities. A number of these facilities have branch services in neighboring locations. Rochester, Winona, Red Wing, Austin, Albert Lea, Owatonna, Mankato, Fairmont, and New Ulm.

Mental Health Centers

Owatonna, Austin, Albert Lea, New Ulm, Rochester, Winona, Mankato, and Fairmont.

Mental Retardation

A. Residential

Group living facilities are located in all counties of the receiving area other than Nicollet.